Joint Designation

May, 2002

Current Joint Designation

- Spokane Level II (Sacred Heart & Deaconess)
- Tacoma Level II (St. Joseph & Tacoma General)
- Tri-Cities Level III (Kadlec, Kennewick, & Lourdes)
- Yakima Level III (Yakima Valley Memorial & Providence Yakima)

Spokane Level II

- Hospitals rotate on a weekly basis
- Each hospital has a trauma director, coordinator and registrar
- Separate medical staff for each hospital
- Joint QI limited by confidentiality concerns

Tacoma Level II

- Hospitals rotate daily (one on/one off)
- Single medical staff (I.e., trauma surgeons cover both hospitals)
- Single medical director
- Each hospital has its own trauma coordinator
- Separate registrars, but joint registry
- Pursuing state coordinated QI program

Tri-Cities Level III

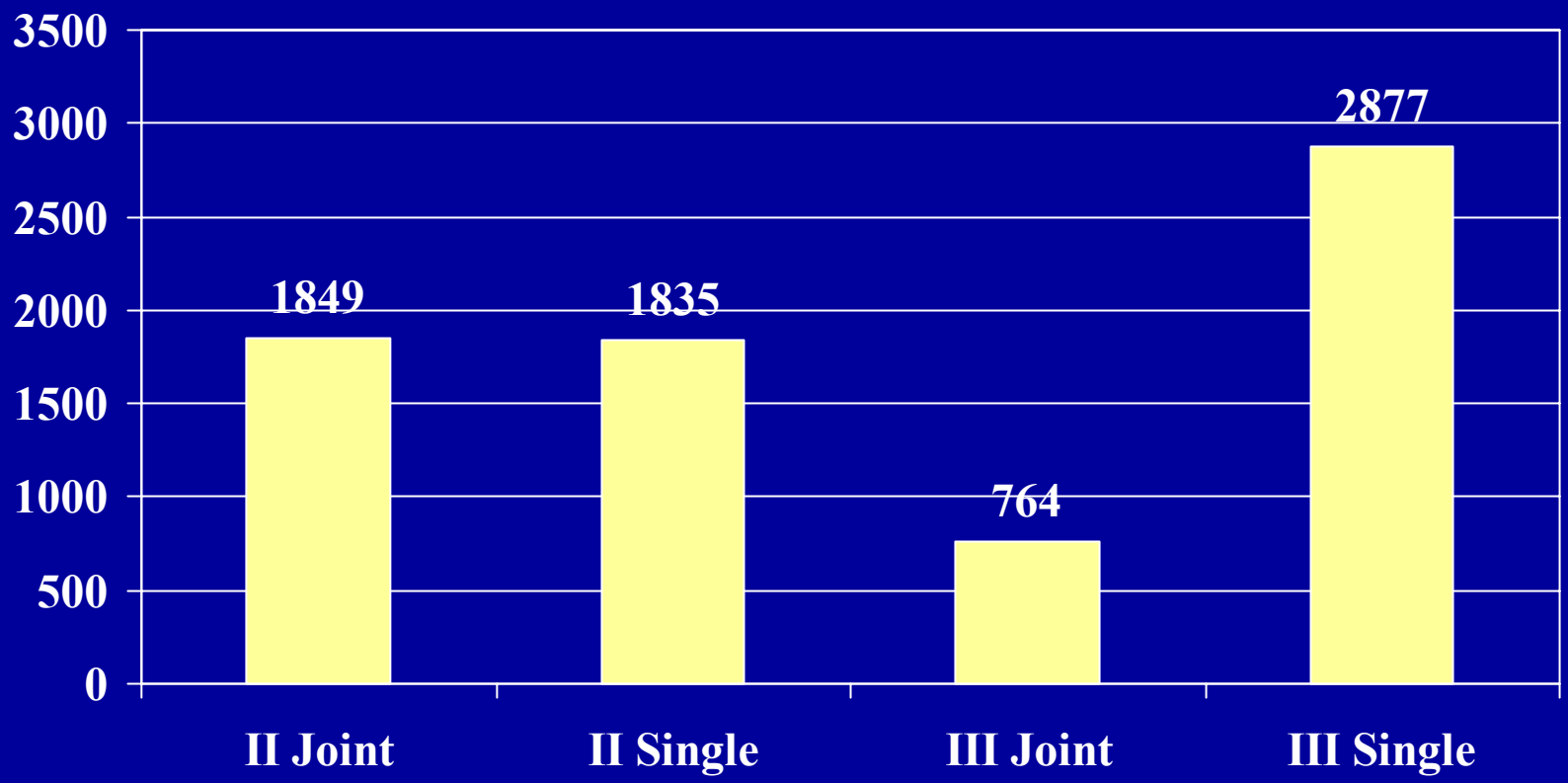
- Kadlec up always; Kennewick and Lourdes rotate based on surgeon call schedule
- Single trauma director, coordinator and registrar
- Single Joint QI process through the state coordinated QI program

Yakima Level III

- Hospitals rotate daily
- Single trauma director
- Single medical staff
- Each hospital has its own trauma coordinator and registrar
- Joint QI in place

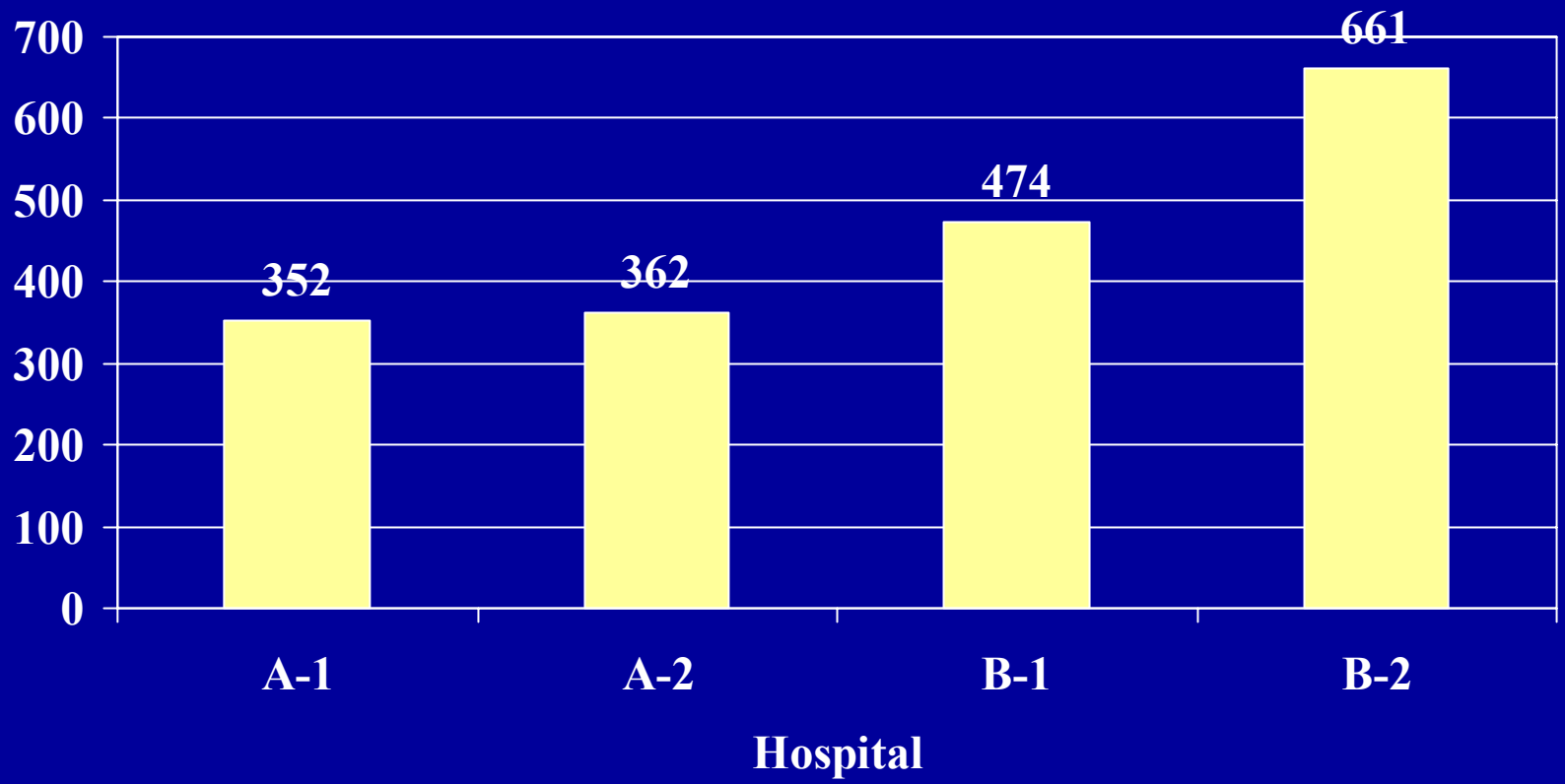
Registry Volume

(DOH Criteria, July 2000 – June 2001)



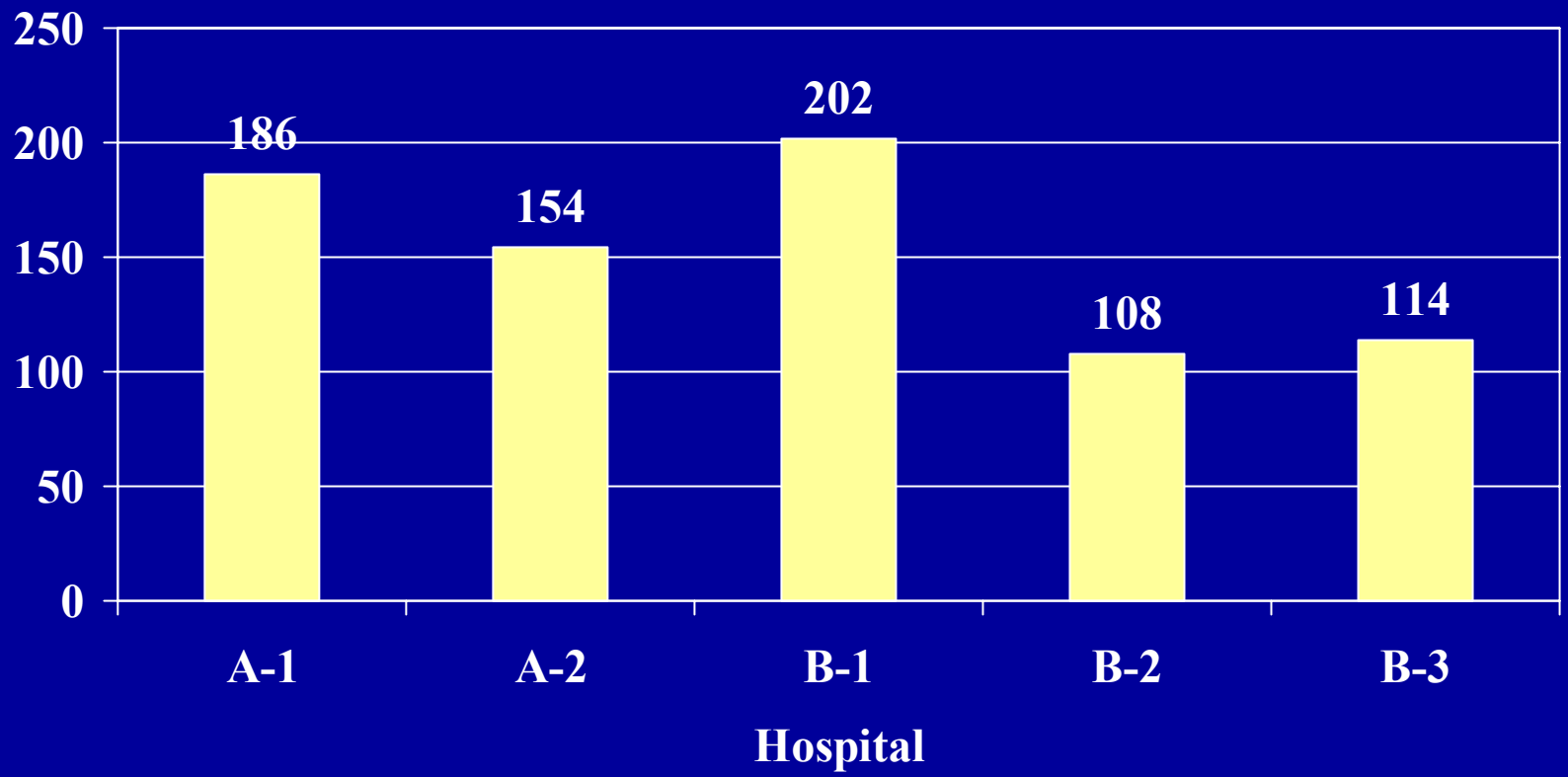
Level II Joint Volume by Hospital

(State criteria, July 2000-June 2001)

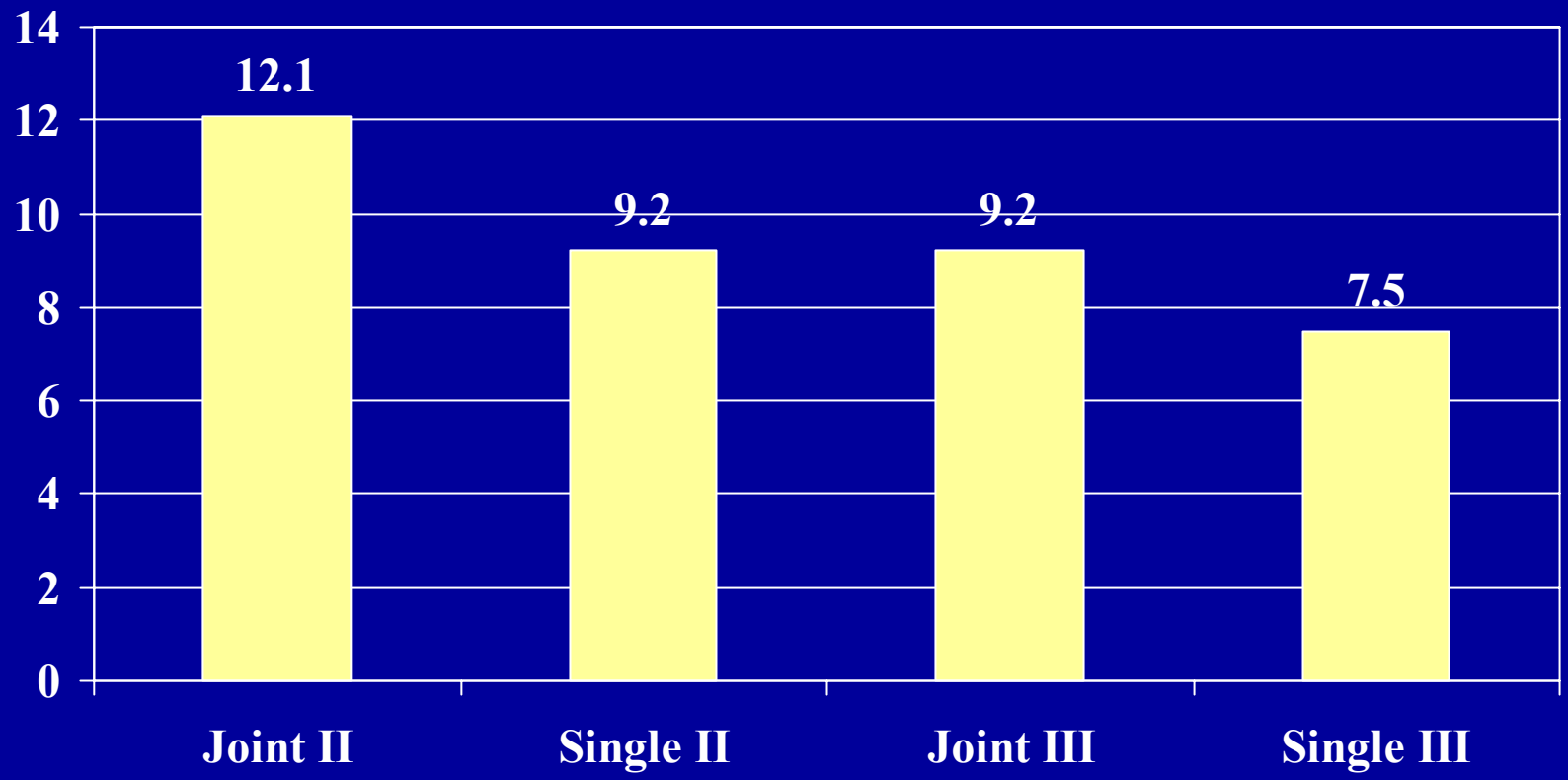


Level III Joint Volume by Hospital

(State criteria, July 2000-June 2001)

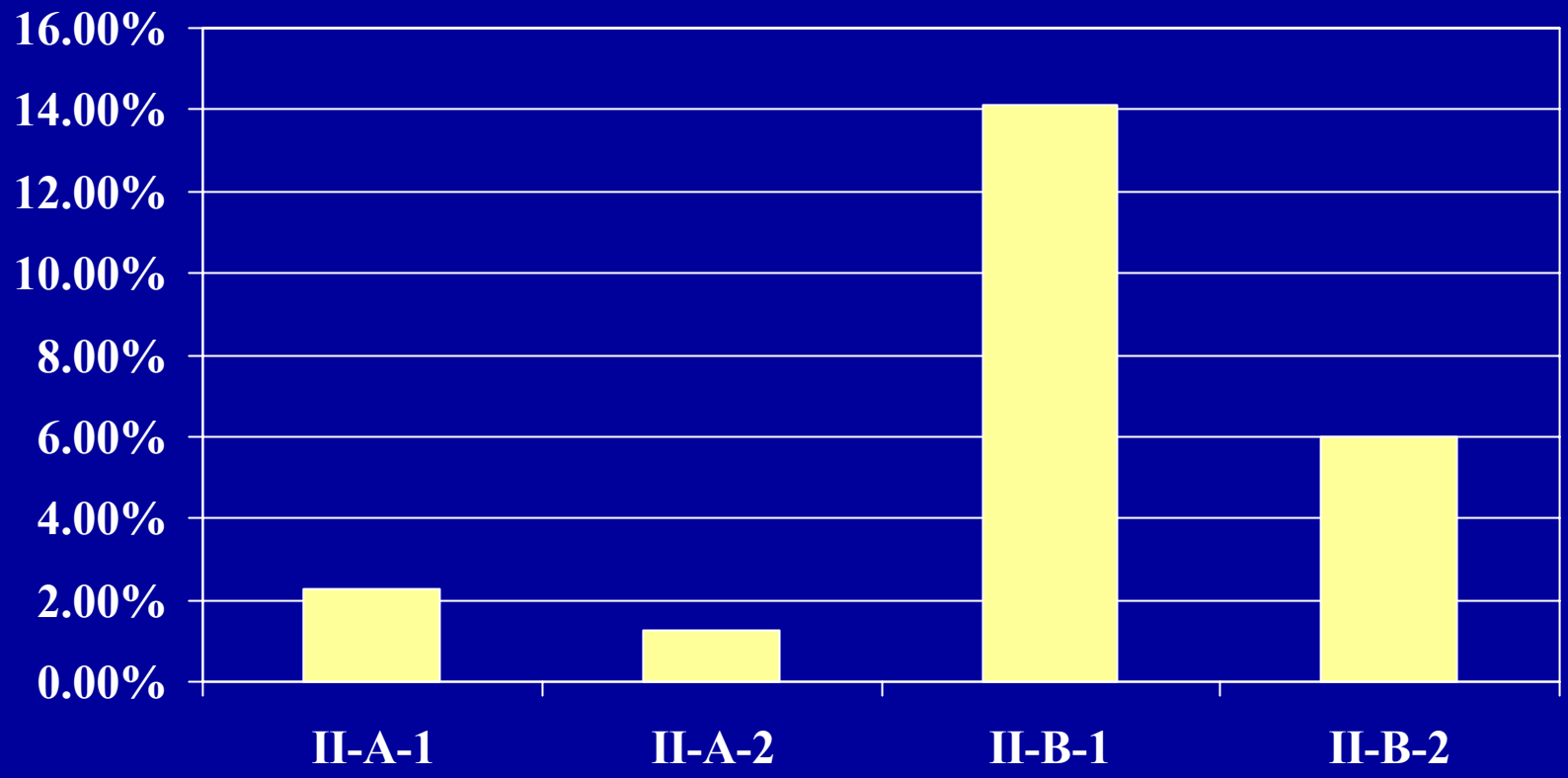


Mean ISS for Admitted Patients
(DOH criteria, July 2000-June 2001)



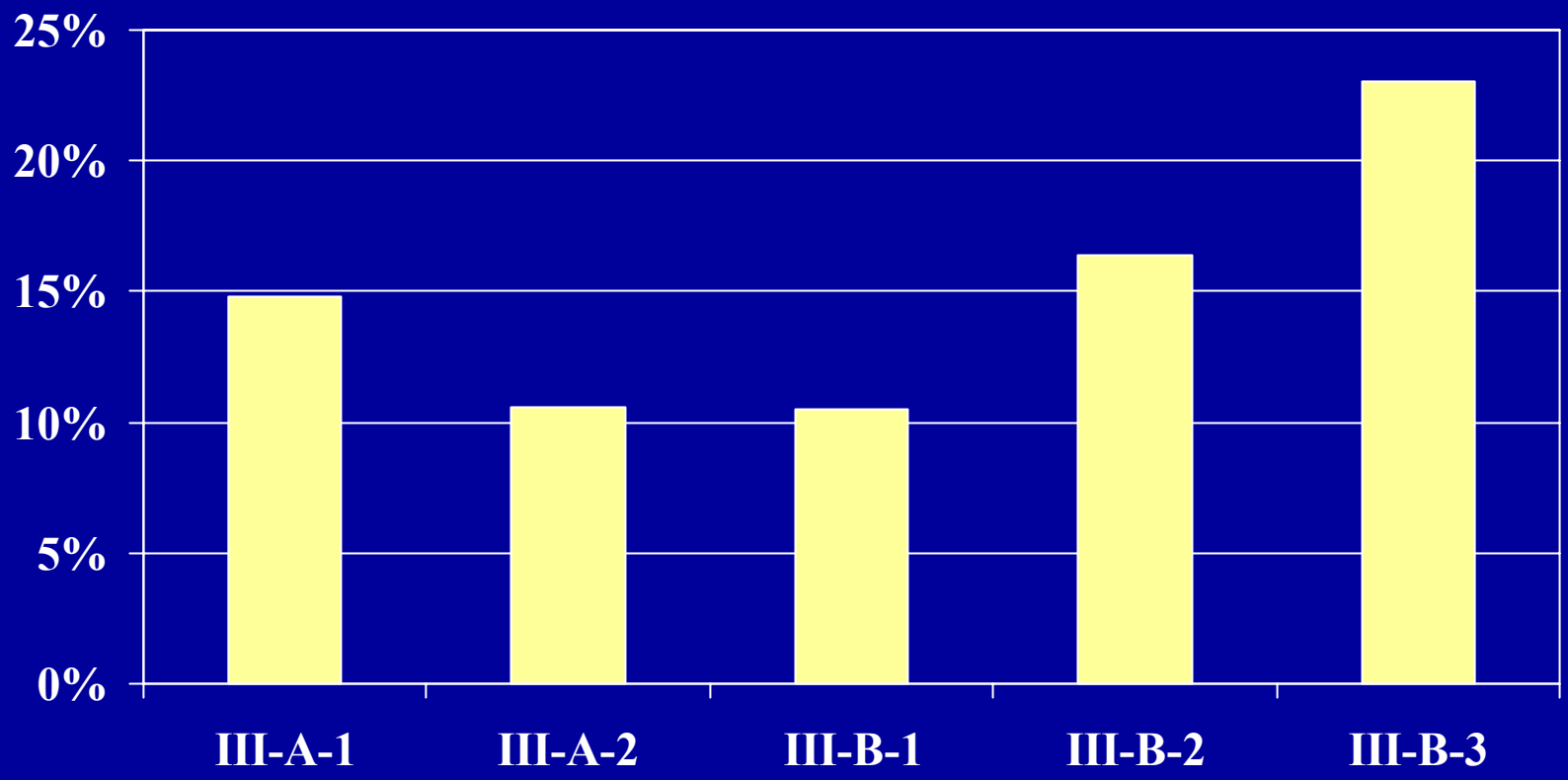
% of Patients Transferred Out of ED

(DOH Criteria, All Years, Joint IIs)



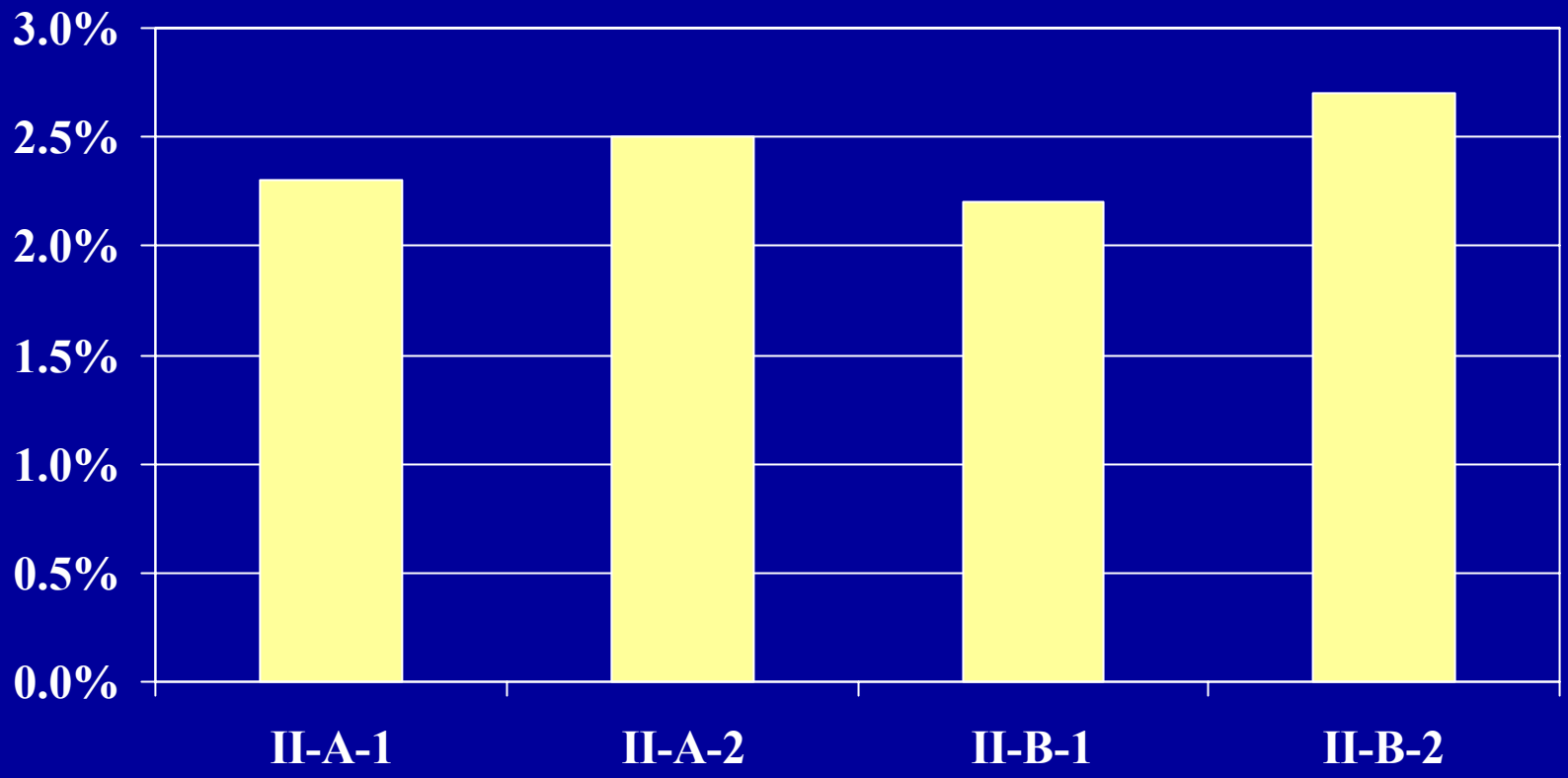
% of Patients Transferred Out of ED

(DOH Criteria, All Years, Joint IIIs)



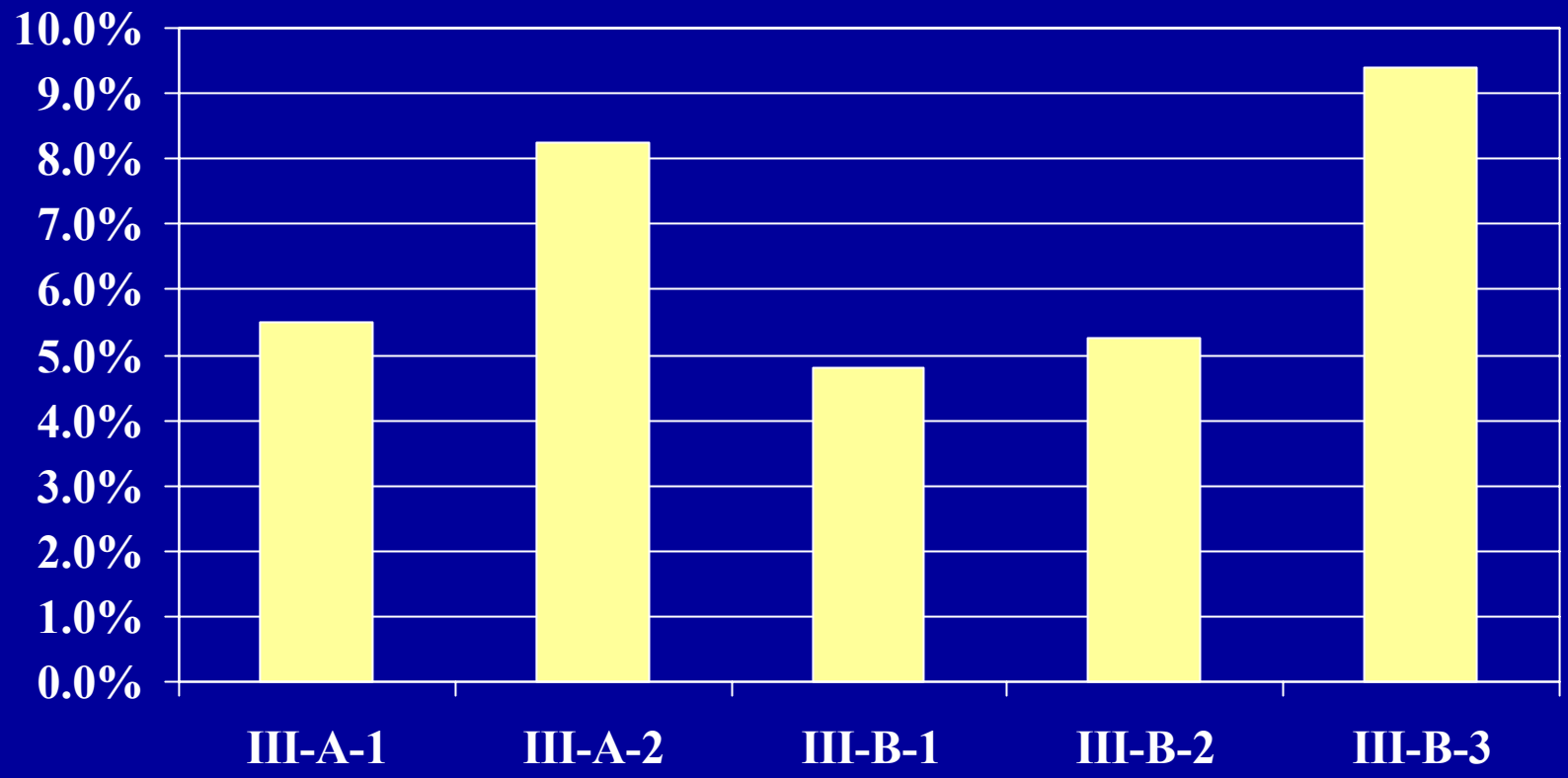
% of Patients Transferred After Admission

(DOH Criteria, All Years, Joint IIs)

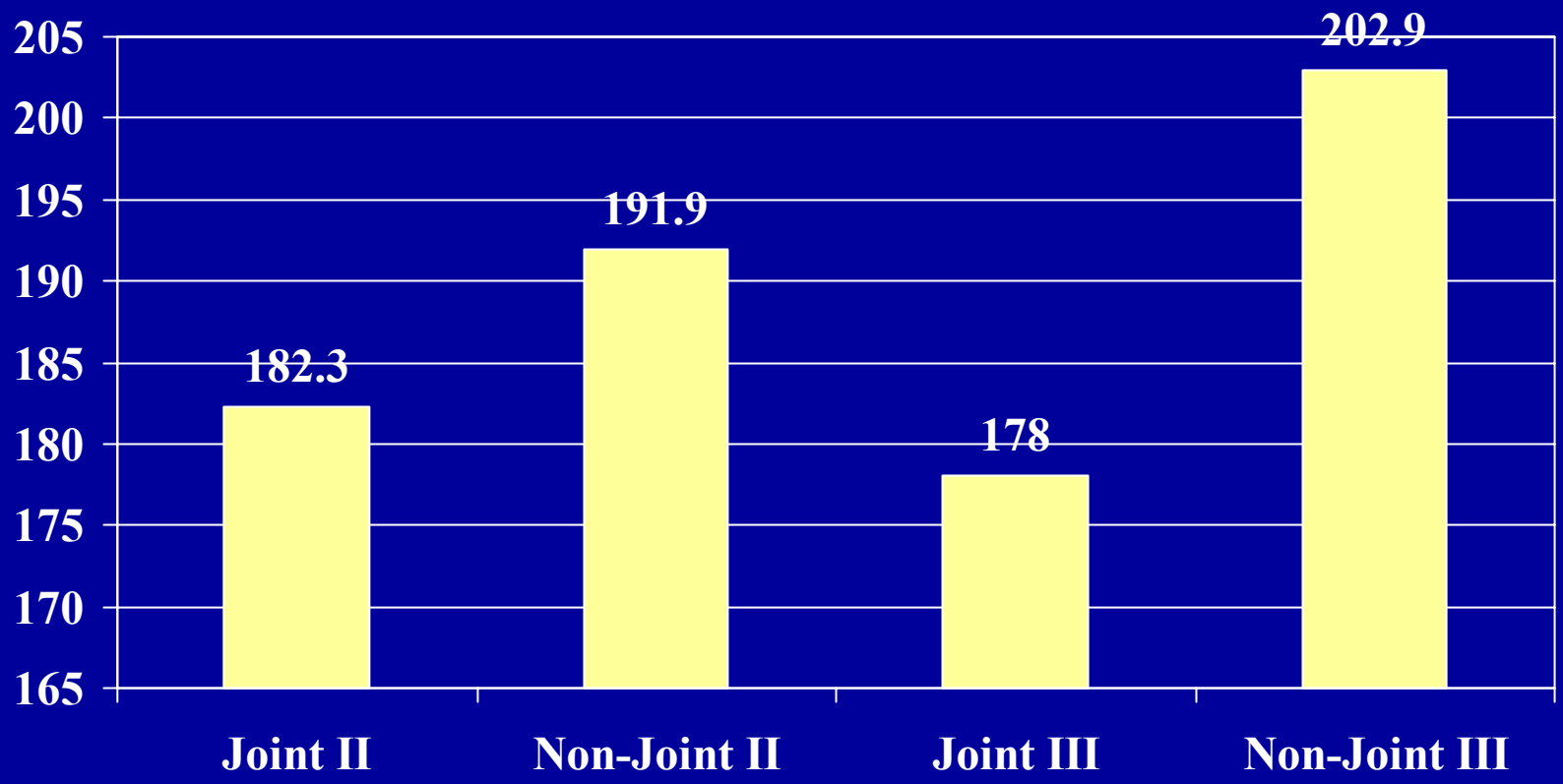


% of Patients Transferred After Admission

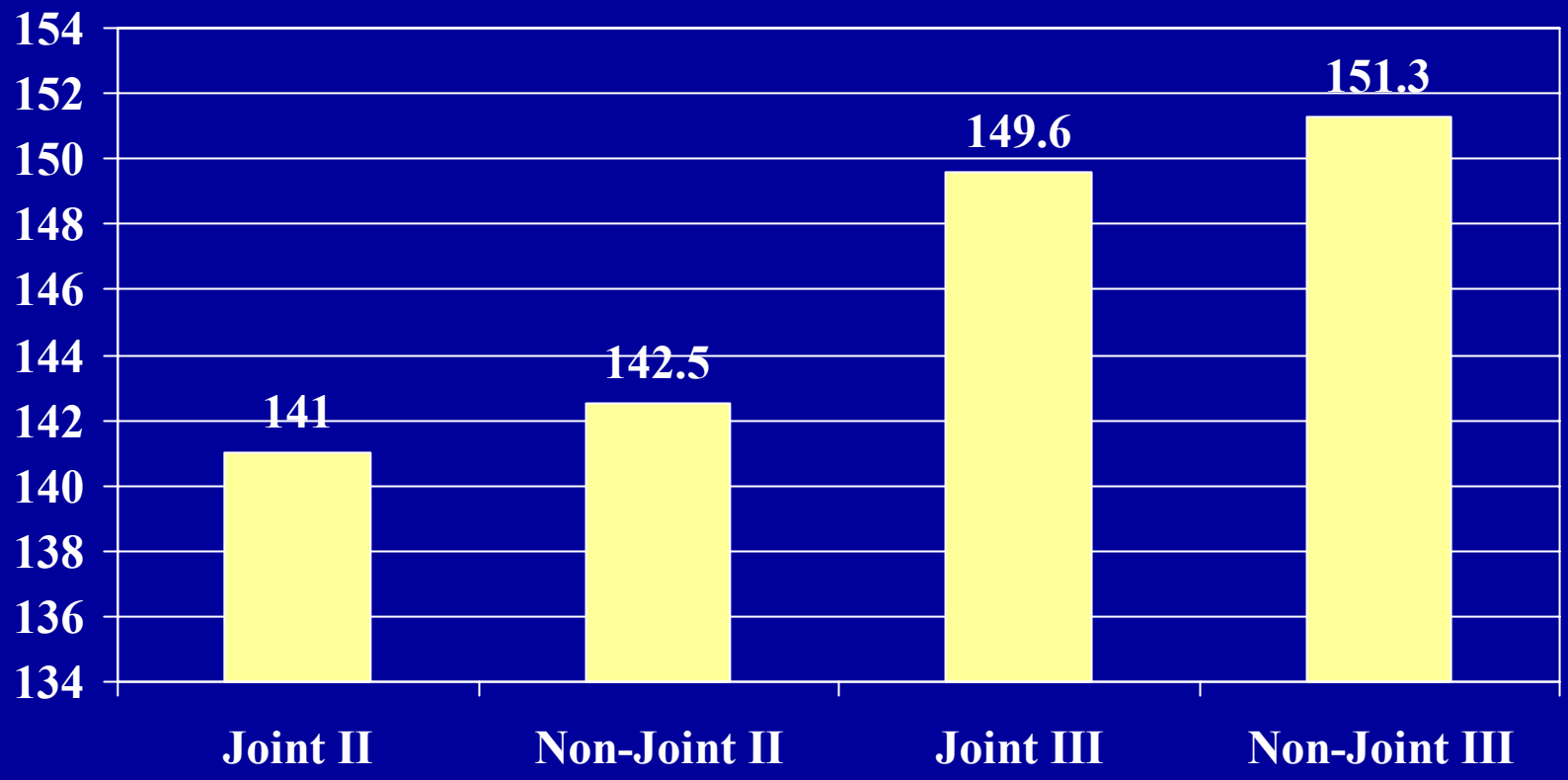
(DOH Criteria, All Years, Joint IIIs)



Mean ED Length of Stay (minutes)

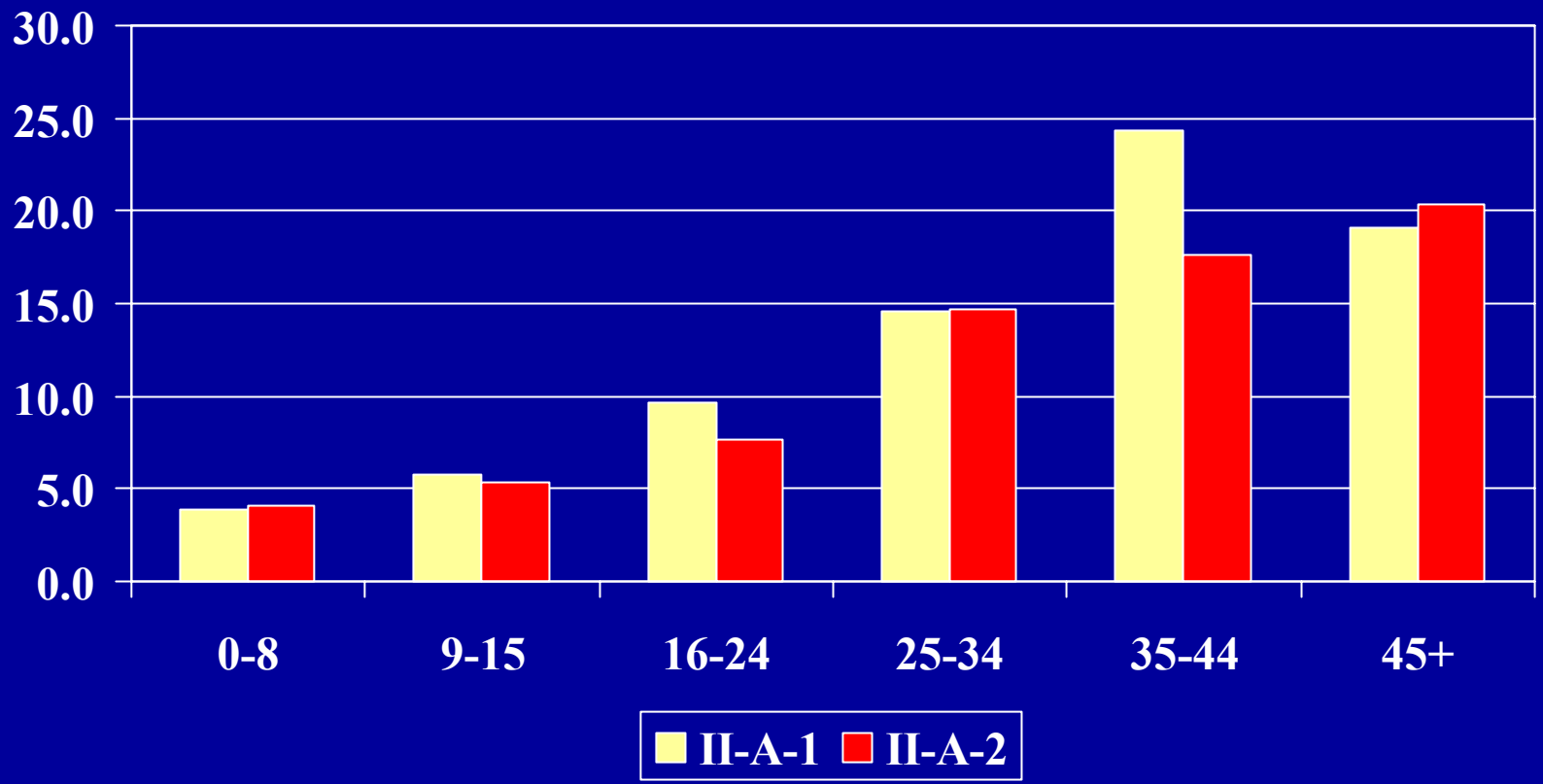


Mean ED Length of Stay if ED to OR (minutes)



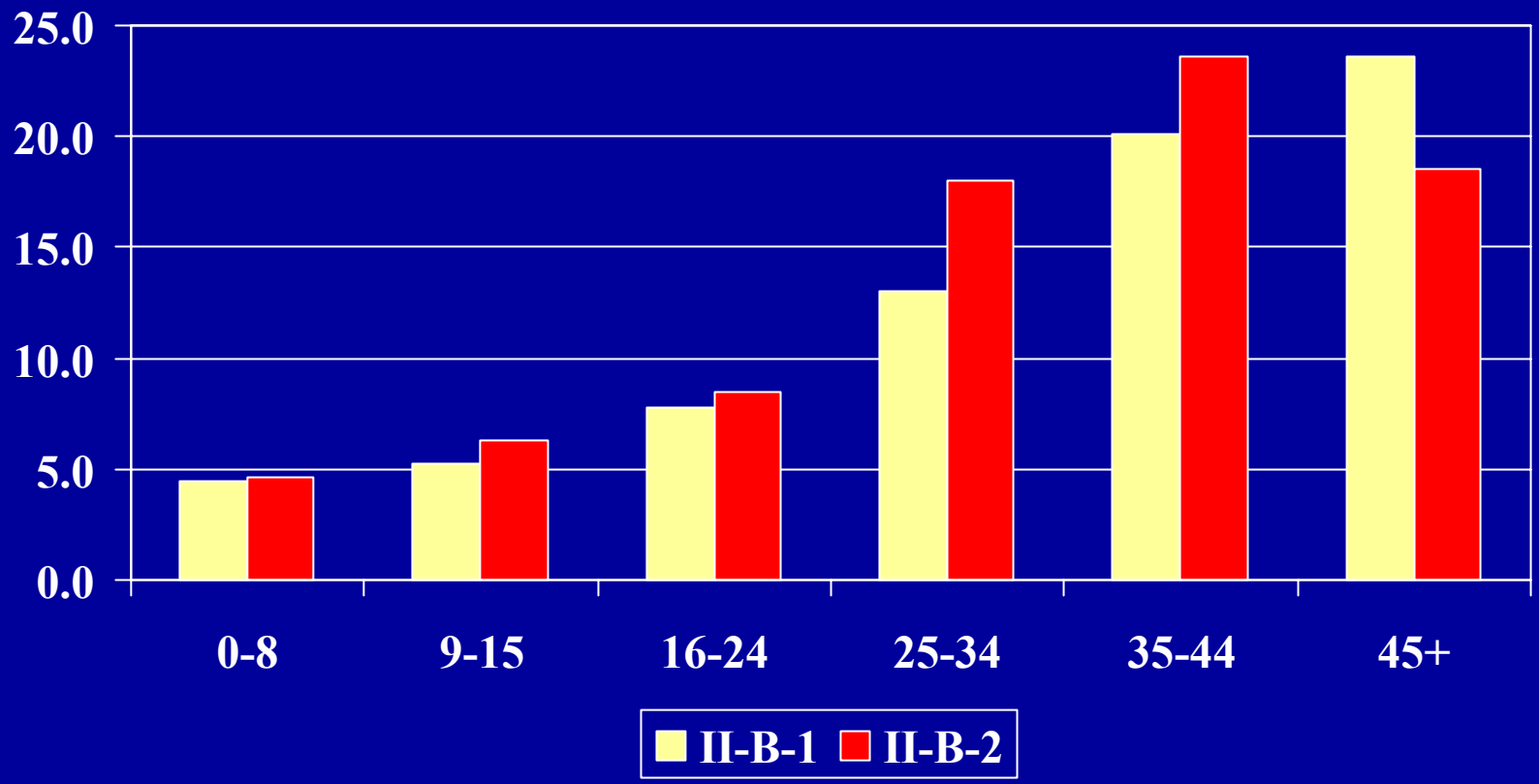
Mean Hospital LOS for Admitted Patients

(DOH Criteria, excluding deaths, All Years, Joint II-A)



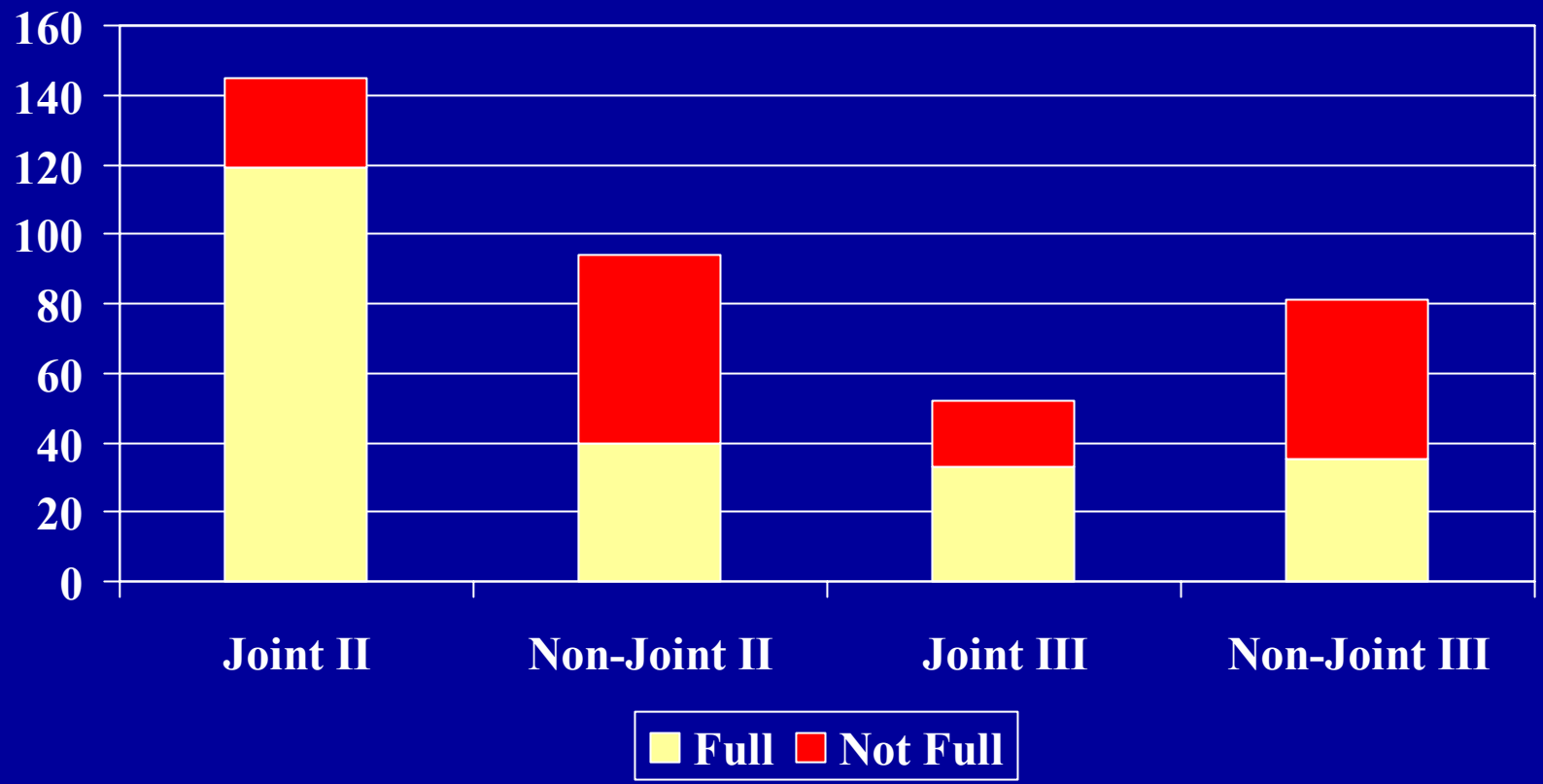
Mean Hospital LOS for Admitted Patients

(DOH Criteria, excluding deaths, All Years, Joint II-B)



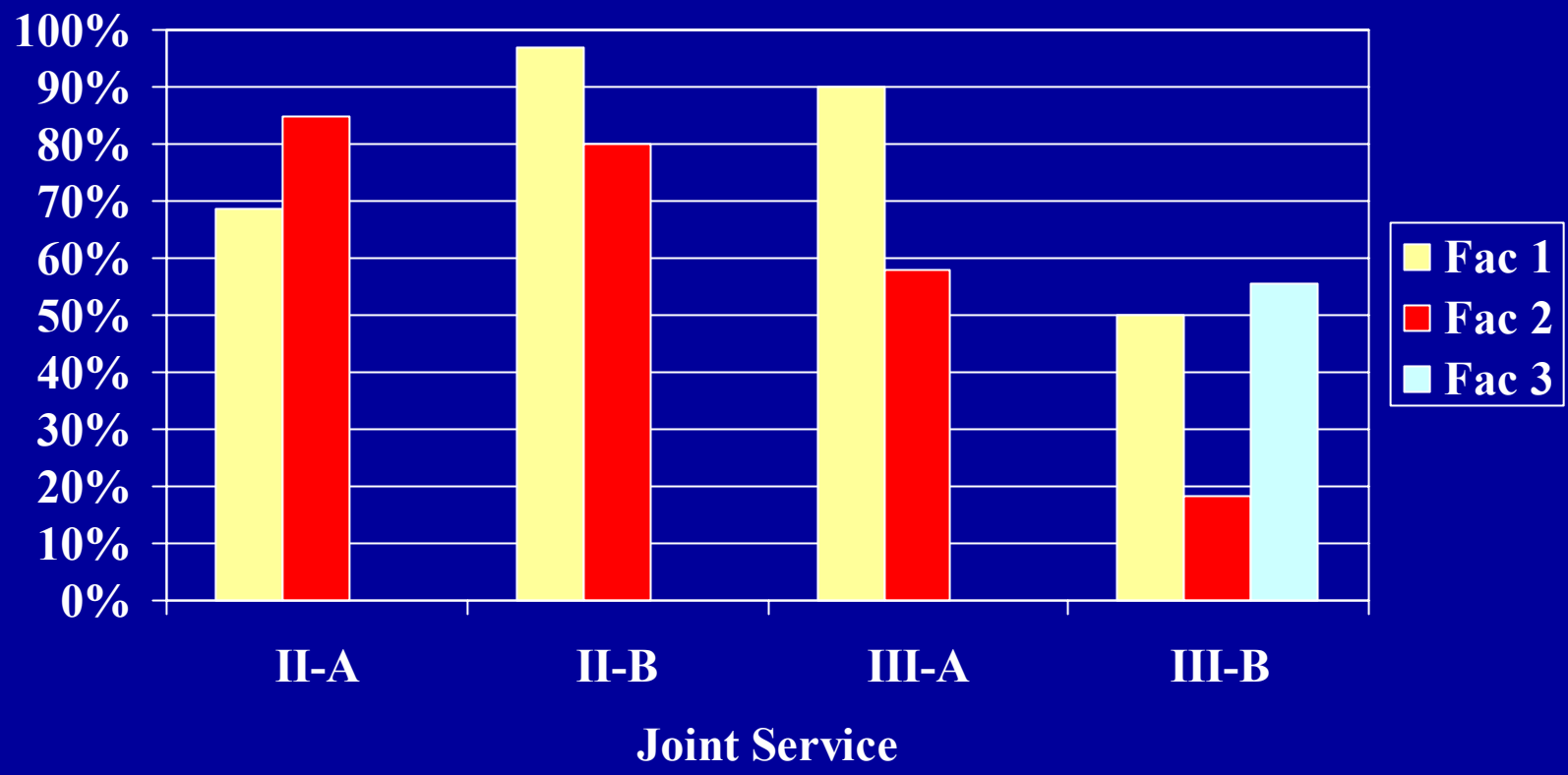
Trauma Team Activation

(Patients with Systolic BP < 90)

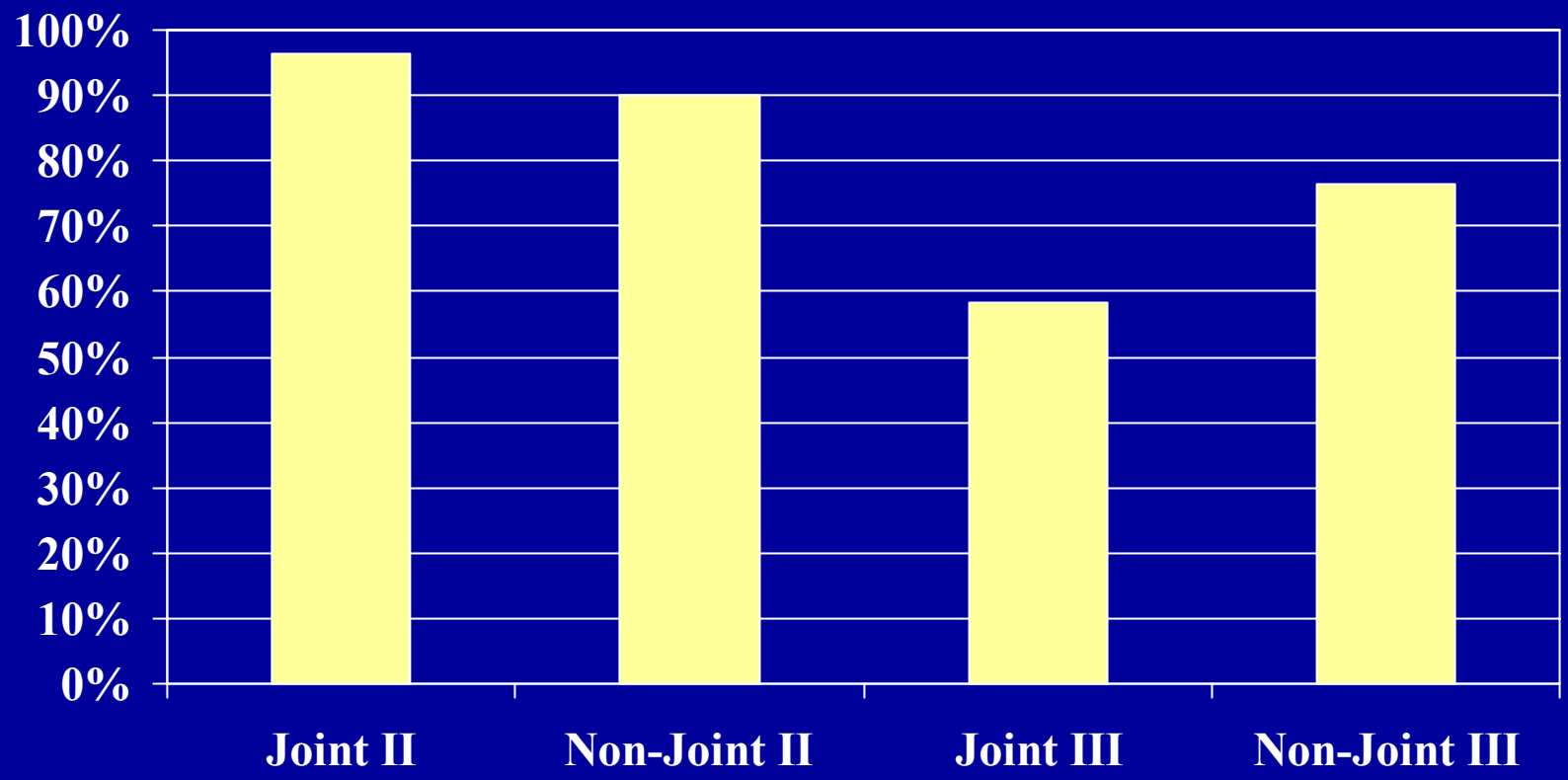


Full Trauma Team Activation

Patients with Systolic BP<90 (Intra-Joint Variability)
DOH Criteria, July 2000-June 2001



Suitability for TRISS Analysis



Mortality – Level II
(DOH Criteria, July 2000 – June 2001)

- Level II Joint (147 deaths out of 1753 admissions) – 8.4%
- Level II Non-Joint (71 deaths out of 1621 admissions) – 4.4%
- After adjusting for injury severity, there was no significant difference in mortality between joint and non-joint level II services.
- Mantel-Haenszel Weighted RR 1.09 (0.85,1.41)

Mortality – Level III

- Level III Joint (40 deaths out of 661 admissions) – 6.1%
- Level III Non-Joint (81 deaths out of 1998 admissions) – 4.1%
- After adjusting for injury severity, there was no significant difference in mortality between joint and non-joint level III services.
- Mantel-Haenszel RR 1.05 (0.74,1.49)

Mortality Variation within Joint II
(DOH Criteria, 1998-2001)

- Level II Joint Service A – Significant difference in mortality between facilities after adjusting for injury severity (Mantel-Haenszel RR 1.41 (95% C.I. 1.14, 1.75))
- Level II Joint Service B – No Significant difference in mortality between facilities (MHRR 1.09 (95% C.I. 0.74, 1.61)

Mortality Variation within Joint
(DOH Criteria, 1998-2001)

- Level III Joint Service A – No significant difference in mortality between facilities (MHRR 0.73. (95% C.I. 0.46, 1.14)
- Level III Joint Service B – No significant difference in mortality between facilities (MHRR 1.27 (95% C.I. 0.84, 1.92)

Unique Issues for Joint Designated Services

- Need to function as one (integration of leadership including administration, medical direction, nursing coordination.)
- Need to have coordinated QI
- Need to coordinate trauma registry operations to assure consistent case ascertainment, data quality and outcomes benchmarking.

Unique Issues for Joint Designated Services

- Need to have predetermined rotation schedules and strong communication with prehospital agencies.
- If specialty services vary between hospitals, prehospital triage needs to address these issues in determining the appropriate destination.

Unique Issues for Joint Designated Services

- Need for common policies and procedures to minimize variability of care between hospitals within a joint service.